PHARMACISTS' BULLETIN

NOVA SCOTIA SENIORS' PHARMACARE PROGRAM

PHARMACARE

NOVA SCOTIA DEPARTMENT OF COMMUNITY SERVICES

March 2006

Vol. #06-03

MARCH BULLETIN

Change to Maximum Allowable Cost List

The Maximum Allowable Cost (MAC) on the following category will be ***effective March 15, 2006*** to reflect changes in the acquisition cost of the lowest priced brand. Enclosed is a replacement page for your February 2006 MAC List which reflects this change.

AZITHROMYCIN 250mg Tab *3.2634*

Reminder . . . .
Nova Scotia Diabetes Assistance Program

The NSDAP (Nova Scotia Diabetes Assistance Program) is a new Pharmacare Program launched on January 1, 2006. This program is subject to the Tariff Agreement negotiated between the Nova Scotia Department of Health and the Pharmacy Association of Nova Scotia. Patients enrolled in the NSDAP are required to submit prescription receipts for their medications and supplies for diabetes. Once their deductible has been completely paid, the patients are reimbursed 80% of the receipt amount for which they are eligible.

Patients who have been accepted into the new NSDAP are mailed two letters confirming their membership in the program. One letter is for the patient's records while the second copy is for their pharmacist. Please insure you see or collect a copy of the letter for your pharmacy records, as this indicates the patients should be billed according to Tariff Agreement for their eligible supplies for diabetes. Billing as a cash customer may result in receipts that are ineligible for payment or patients being reimbursed less than expected.

All over-the-counter supplies (OTC) for diabetes(i.e., strips, needles, lancets, syringes) require a prescription from a licensed prescriber to be eligible for reimbursement as per pharmacare tariff guidelines. Pharmacare cannot honor "OTC" receipts.

Revisions to Ostomy Benefit List

Please be advised of the following corrections to the Ostomy Benefit List. (Please refer to the Nova Scotia Formulary, Miscellaneous Section, page 12.)

The following products were listed with incomplete PINs. Please note the correct PINs are listed below.

PIN	PRODUCT DESCRIPTION	PROD.#	MFR
95098862	Assura Irrigation Sleeve	1003	COL
95098861	Assura Irrigation Sleeve	12834	COL
95098860	Assura Irrigation Sleeve	12835	COL
95098859	Assura Irrigation Sleeve	12836	COL

The PINs for the Hollister CenterPointLock Irrigation Sleeves appear twice on the ostomy list. The products listed with the description "*CenterPointLock Irrig Sleeve*" show the correct PIN and product number. Please disregard the listing for these PINs with the description "*Irrigator Sleeve w Closure*". The following is for your reference.

PIN	PRODUCT DESCRIPTION	PROD.#	MFR
95099425	CenterPointLock Irrig Sleeve	3823	HOL
95099424	CenterPointLock Irrig Sleeve	3824	HOL
95099423	CenterPointLock Irrig Sleeve	3826	HOL
95099427	CenterPointLock Irrig Sleeve	3827	HOL

New Nurse Practitioners

The following nurse practitioners have been added to this group of prescribers.

Carla Burgess	(License #725610)
Geralynn Hirsch	(License #719144)
Terrilee O'Connell-Vacon	(License #730274)

Please retain for your reference. See the Nova Scotia Formulary for Pharmacare benefits which can be insured if prescribed by nurse practitioners.

INCLUDED WITH THIS BULLETIN:

- **Interchangeable Products List** *eff. March 15, 2006*
- **Replacement page for February 2006 MAC List**

OLANZAPINE

The following criteria for Olanzapine (Zyprexa®) has been revised and includes maintenance therapy when a patient is started on olanzapine and is doing well.

- for the treatment of schizophrenia and related psychotic disorders upon the written request of a psychiatrist, either first line or upon failure of other antipsychotic agents
- for the acute treatment of manic or mixed episodes in bipolar I disorder in patients with intolerance or a history of failure to one other atypical antipsychotic
- approved for maintenance therapy in patients with bipolar disease who are currently stabilized on olanzapine

THIAZOLIDINEDIONES

The criteria for Thiazolidinediones (Pioglitazone, Rosiglitazone) has been revised to allow coverage in patients with the following criteria. This revision requires a patient to have a recent A_{1C} of < 10% , unless insulin therapy is inappropriate for the patient:

- for treatment of Type II diabetes in patients who have:
  - inadequate glycemic control[1] on optimal doses[2] of sulfonylurea and metformin; *or*
  - demonstrated intolerance or contraindication to metformin[3] and are on optimal doses[2] of sulfonylurea; *or*
  - demonstrated intolerance or contraindication to sulfonylurea[4] and are on optimal doses[2] of metformin; *or*
  - inadequate glycemic control[1] on optimal doses[2] of metformin and a BMI ≥27. (A glitazone is recommended over a sulfonylurea (second line to metformin).)
- patients must have a recent A_{1C} of < 10% unless insulin therapy is inappropriate for the patient. Duration of initial approval will be 6 months; further coverage will require demonstrated evidence of efficacy (a reduction of A_{1C} of 0.7 observed to continue therapy).

---

1 A_{1C} >7% and <10%

2 Maximum doses: metformin 2000mg/day, glyburide 10mg bid

3 Metformin: Intolerance-GI adverse effects; Contraindications renal impairment or hepatic failure (cautious repaglinide use preferred to rosiglitazone in hepatic failure patients), acute or chronic metabolic acidosis.

4 Sulfonylureas: Intolerance - hypoglycemia; Contraindications - sulfa allergy, severe renal insufficiency

LAMOTRIGINE

The criteria for Lamotrigine (Lamictal®) has been revised:

- for adjunctive management of epilepsy not satisfactorily controlled by conventional therapy
- for treatment of bipolar disorder in patients who have intolerance or a history of failure to lithium

RESPIRATORY FLUROQUINOLONES

The criteria for Respiratory Fluroquinolones (Gatifloxacin, Levofloxacin, Moxifloxacin) has been expanded to include the treatment of community acquired pneumonia in patients with comorbidity upon radiographic confirmation of pneumonia **or** who have failed first line therapies. The expanded criteria also includes the treatment of Group II AECB patients who have failed first line therapies. The criteria is:

- for the completion of therapy instituted in the hospital setting for the treatment of nosocomial, community acquired pneumonia (CAP) or acute exacerbation of chronic bronchitis (AECB) [*Criteria Code 01*]
- for the treatment of severe pneumonia in nursing home patients [*Criteria Code 02*]
- for the treatment[1] of CAP in patients
  - with comorbidity[2] upon radiographic confirmation of pneumonia, *or*
  - who have failed[3] first line therapies (macrolide, doxycycline, amoxicillin-clavulanate)
- for the treatment[1] of Group II AECB patients who have failed[3] treatment with one of the following: amoxicillin, doxycycline, TMP-SMX, cefuroxime, macrolide, ketolide or amoxicillin-clavulanate. Group II AECB patients have an FEV_1 < 50% predicted or an FEV_1 between 50% and 60% predicted but have significant comorbidity[2] and/or experience ≥4 exacerbations per year.

---

1 If treated with an antibiotic within the past 3 months choose an antibiotic from a different class.

2 Comorbidity includes chronic lung disease, malignancy, diabetes, liver, renal or congestive heart failure, use of antibiotics or steroids in the past 3 months, suspected macroaspiration, hospitalization within last 3 months, HIV/AIDs, smoking, malnutrition or acute weight loss.

3 Defined by clinical deterioration after 72 hours of antibiotic treatment or lack of improvement after completion of antibiotic treatment.

INTERCHANGEABLE PRODUCTS ADDED TO NOVA SCOTIA FORMULARY

Effective March 15, 2006

EXISTING CATEGORIES:

Note: For those products with benefit status under the Nova Scotia Pharmacare Programs, the existing MAC will apply.

	DIN	Product	MFR	Benefit Status
ALENDRONATE 5mg Tab	02270110	Gen-Alendronate	GPM	not insured
ALENDRONATE 10mg Tab	02270129	Gen-Alendronate	GPM	E
ALENDRONATE 70mg Tab	02273179	pms-Alendronate	PMS	E
AZITHROMYCIN 250mg Tab	02261634	pms-Azithromycin	PMS	E
AZITHROMYCIN 600mg Tab	02261642	pms-Azithromycin	PMS	E
BUSPIRONE HCl 10mg Tab	02262916	Co Buspirone	COB	SFC
CARVEDILOL 3.125mg Tab	02268027	RAN-Carvedilol	RBX	E
DOMPERIDONE MALEATE 10mg Tab	02268078	RAN-Domperidone	RBX	SFC
IPRATROPIUM BROMIDE 200mcg/mL & **SALBUTAMOL** 1mg/mL Unit Dose Inh Sol	02272695	Gen-Combo Sterinebs	GPM	E
LOVASTATIN 20mg Tab	02267969	RAN-Lovastatin	RBX	SF
LOVASTATIN 40mg Tab	02267977	RAN-Lovastatin	RBX	SF
METFORMIN HCl 500mg Tab	02269031	RAN-Metformin	RBX	SFD
METFORMIN HCl 850mg Tab	02269058	RAN-Metformin	RBX	SFD
MIRTAZAPINE 30mg Tab	02270927	ratio-Mirtazapine	RPH	SFC
	02267292	Sandoz-Mirtazapine FC	SAN	SFC
ZOPICLONE 5mg Tab	02271931	Co Zopiclone	COB	SFC*
ZOPICLONE 7.5mg Tab	02271958	Co Zopiclone	COB	SFC*

DIN CHANGE:

NOTE: The respective manufacturer has given notification of the following change in DIN and product formulation. The new DIN is approved for interchangeability in the existing category. The old DIN will continue to be insured until existing stock is depleted but will be removed from future formulary pages.

	Product	MFR	OLD DIN	NEW DIN
MOMETASONE 0.1% Oint	pms-Mometasone	PMS	02244769	02270862

*Special MAC applies

NEW CATEGORIES:

Note: Until a MAC price is established, AAC will be paid for those products with benefit status under the Nova Scotia Pharmacare Programs. These categories will appear in the next publication of the MAC List.

	DIN	Product	MFR	Benefit Status
BICALUTAMIDE 50mg Tab	02184478	Casodex	AZE	SFC
	02274337	Co Bicalutamide	COB	SFC
	02270226	Novo-Bicalutamide	NOP	SFC
	02275589	pms-Bicalutamide	PMS	SFC
	02276089	Sandoz-Bicalutamide	SDZ	SFC
DILTIAZEM 120mg ER Cap	02271605	Novo-Diltiazem HCL ER	NOP	SF
	02245918	Sandoz-Diltiazem T	SDZ	SF
	02231150	Tiazac ER	BVL	SF
DILTIAZEM 180mg ER Cap	02271613	Novo-Diltiazem HCL ER	NOP	SF
	02245919	Sandoz-Diltiazem T	SDZ	SF
	02231151	Tiazac ER	BVL	SF
DILTIAZEM 240mg ER Cap	02271621	Novo-Diltiazem HCL ER	NOP	SF
	02245920	Sandoz-Diltiazem T	SDZ	SF
	02231152	Tiazac ER	BVL	SF
DILTIAZEM 300mg ER Cap	02271648	Novo-Diltiazem HCL ER	NOP	SF
	02245921	Sandoz-Diltiazem T	SDZ	SF
	02231154	Tiazac ER	BVL	SF
DILTIAZEM 360mg ER Cap	02271656	Novo-Diltiazem HCL ER	NOP	SF
	02245922	Sandoz-Diltiazem T	SDZ	SF
	02231155	Tiazac ER	BVL	SF
GLIMEPIRIDE 1mg Tab	02245272	Amaryl	SDZ	not insured
	02273101	ratio-Glimepiride	RPH	not insured
	02269589	Sandoz-Glimepiride	SDZ	not insured
GLIMEPIRIDE 2mg Tab	02245273	Amaryl	SDZ	not insured
	02273128	ratio-Glimepiride	RPH	not insured
	02269597	Sandoz-Glimepiride	SDZ	not insured
GLIMEPIRIDE 4mg Tab	02245274	Amaryl	SDZ	not insured
	02273136	ratio-Glimepiride	RPH	not insured
	02269619	Sandoz-Glimepiride	SDZ	not insured
LEVETIRACETAM 250mg Tab	02274183	Co Levetiracetam	COB	E
	02247027	Keppra	VLH	E
LEVETIRACETAM 500mg Tab	02274191	Co Levetiracetam	COB	E
	02247028	Keppra	VLH	E
LEVETIRACETAM 750mg Tab	02274205	Co Levetiracetam	COB	E
	02247029	Keppra	VLH	E